

lower and upper extremities; in the latter no reflexes could be obtained, and there was marked muscular weakness. The speech was slow but not ataxic. The electrical and ophthalmoscopic examinations were negative. There was no spinal curvature. In the earlier and more active stage of the disease in the history of this patient there had been decidedly spastic symptoms.

The author gives a very interesting discussion of the symptoms observed, and of the views of different writers with regard to the nature and cause of the affection.

CONTRIBUTION TO THE STUDY AND HISTORY OF WEIL'S DISEASE.

WEISS (*Centralbl. f. klin. Med.*, 1890, No. 38, 688) defines this disease as a suddenly-developing, acute, febrile affection, arising without discernible cause, accompanied by icterus, swelling of the liver and spleen, and renal and severe nervous symptoms, and running a short and favorable course. He reviews the cases which have been already reported, many of which he feels obliged to consider as not genuine examples of the disorder. He then reports a number of cases recently treated by him, as well as a large number of others which came under his observation in a small epidemic in 1866, and which he published under the title of "Infectious Icterus" before Weil's observations were made. As French authors also described it before Weil, he suggests that it be designated "*Typhus biliosus nostras*."

The symptoms are of two classes—pathognomonic and accidental. To the first belong the sudden-development of high fever, usually with chilliness or rigor; cerebral symptoms and muscular pains; disturbances of the digestive apparatus; icterus and swelling of the liver from biliary congestion; enlargement of the spleen; renal symptoms. To the second class belong cutaneous eruptions, as roseola, erythema, purpura, petechiæ, herpes labialis or nasalis, epistaxis, bronchitic symptoms.

Males are much more frequently affected, and usually between the ages of fifteen and thirty years. Most cases occur during the summer. The hygienic and sanitary conditions of places in which the disease has occurred have been recognized by all observers as bad. No positive case of direct transmission of the disease has as yet been observed.

As exciting causes there have been mentioned errors in diet, exposure to cold, over-exertion, ingestion of bad beer; but the true etiology of the disease has not yet been discovered, and the investigation of the blood for bacteria, carried out by some writers, has had but negative results. Though the affection has ended fatally, yet the prognosis is usually favorable. The recovery, however, is tedious. The severity depends upon the degree of the renal involvement.

THE AMŒBA COLI IN DYSENTERY.

LAFLEUR (*Johns-Hopkins Hosp. Bull.*, 1890, No. 7, 91) reports a case of dysentery in which the amœba coli were found in the stools. The patient, a man of twenty-seven years of age, a seaman, had been in the tropics for a short time in 1880, but not since. While at sea, two weeks before coming under observation, he had slight epistaxis, vomiting, and diarrhœa, and after a week numerous bloody stools, with tenesmus and abdominal pain. On

admission to the hospital his stools were greenish-brown, watery, foetid, and contained blood, mucus, shreddy detritus, and scattered masses of pus. Numerous amœbæ were found actively moving in the stools. They varied considerably in size, the average being five to seven times that of a leucocyte. They were pale bluish-green in color, and contained one to many small vacuoles surrounded by highly-refracting granular particles, the whole being invested by a homogeneous outer zone looking like finely-ground glass. In some it was possible to make out a circular nucleus. Several stools were examined every day, and amœbæ always discovered. Small grayish-yellow pus collections, which could be easily picked out with the forceps from the fluid part of the stools, exhibited the organisms to the best advantage. This is the second case of dysentery reported in this country in which the amœbæ have been found.

THE VALUE OF THE PHENYLHYDRACIN TEST FOR SUGAR.

HIRSCHL (*Centralbl. f. d. med. Wissensch.*, 1890, No. 38, 691), in investigating the value of this test for sugar in the urine, found that out of forty-five different specimens of urine only four exhibited the characteristic yellow needles of phenylglucosazone, with a melting-point of 205° C., and that in these four urines the fermentation-test also gave a positive result. The other urines gave only the yellowish-brown masses, strongly refractive globules, and irregular thorn-apple forms of a melting-point of about 150° C., while the fermentation-test was negative. He therefore considers the phenylhydracin test reliable for sugar in the urine. Ten c.cm. of the urine should be mixed with twice as much of the reagent as will lie upon the point of a knife and with three times this unit of acetate of soda. This mixture should then be heated at least an hour on a water-bath, allowed to stand over-night, and the sediment examined microscopically. Levulose gives, it is true, the same osazone as grape-sugar. If, therefore, a polariscopic examination of the urine shows no deviation of the light to the right, the presence of levulose in the urine may be assumed. The combination of phenylhydracin with lactose produces bright-yellow needles ten times as wide as phenylglucosazone, while maltose produces an osazone in the form of broad, yellow plates of a melting-point of 82° C.

THE CAUSES AND TREATMENT OF CHRONIC CONSTIPATION.

KOGERER (*Wien. klin. Wochenschr.*, 1890, No. 33, 638) says that, though a person whose bowels are regular will have one or two, or, rarely, even three, passages daily, it is possible for an individual to suffer from chronic constipation and yet to have the bowels moved as frequently as this. In these cases the passages are only the overflow, while the greatest portion of the faecal mass remains in the large intestine. It is to be borne in mind that such persons may even suffer from chronic diarrhoea.

In discussing the numerous causes of constipation, the author mentions as one of the chief the voluntary neglect of the natural inclination to stool. Among other causes are an insufficient ingestion of fluid; the loss from the economy of large amounts of water, as in profuse sweating, etc.; an insufficient secretion of the digestive juices, especially bile; the ingestion of certain drugs;